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## Provocative Therapy with the Hearing Impaired Client

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## PROVOCATIVE THERAPY WITH THE HEARING IMPAIRED CLIENT

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Provocative therapy is a psychotherapy system developed by Frank Farrelly in the early 1960's. The provocative therapist's interventions are designed initially to provoke the client's maladaptive behaviors, assumptions, and feelings. Next, the interventions mobilize the client's own resistance and defenses against these maladaptive behaviors in order to elicit behaviors that are self-and-other-enhancing. Provocative therapy has been successfully employed with hearing clients in all psychiatric diagnostic categories from pre-school to geriatric age groups, with intellectual levels ranging from the educable mentally retarded to the genius, and with members of varying ethnic and racial groups. In addition, this therapy has been practiced in both hospitals and out-patient clinics with individuals, groups, families, and couples.

Frequently, hearing impaired clients feel isolated, alienated, lonely, alone, and misunderstood; these *feelings*, as any experienced therapist realizes, are not solely the province of hearing impaired people, and by conveying their understanding of these common human experiencings, therapists can readily scale the walls of isolation and bridge the gulfs of loneliness that seem to separate such clients from others. The authors of this paper adopt the stance that hearing impaired clients can be free, responsible, and powerful enough to make self-and-other-enhancing choices and, with our help, direct their own lives. Provocative therapy with the hearing impaired client is one way of connecting them with their responsibility, choices, and

power of self direction. The purpose of our paper is to describe provocative therapy and suggest its uses and possibilities with hearing impaired clients.

To utilize provocative therapy with a hearing impaired person who communicates with sign language, a therapist should ideally be trained in sign language, psychosocial aspects of deafness, or at least work with the assistance of a trained interpreter with knowledge about deafness. Provocative therapy, because of its specificity, imagery, similes, and its thrust at using any mode of communication to establish contact or "get through" to the client, would seem especially suited to working with hearing impaired individuals. The therapy engages issues quickly and provokes the client's assumptive sets and psychological blind spots which frequently can be as handicapping as deafness itself (See Farrelly 1974, p. 121). We are simply assuming all clients can be communicated with, using provocative therapy, and that these clients can be directly or indirectly persuaded to change.

### Theory

Provocative therapy did not evolve in a lockstep, rigid progression. This approach was discovered by the trial and error of practicing therapy. The separate, and at times seemingly disparate, findings that emerged from the "laboratory" of the interviewing room led to various therapeutic assumptions. These assumptions are badly stated here with few explanatory sentences;

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space limitations necessitate this brief description. We refer the reader to the book *Provocative Therapy* (Frank Farrelly and Jeff Brandsma, 1974) for more extensive discussion of these points.

*Assumption 1: People change and grow in response to challenge.* If presented with a non-overwhelming challenge with which the client is forced to cope and unable to avoid, the client's *constructive* anger or "fight" response can be provoked to create change in the client's behavior and attitudes. Pairing emotional honesty and confrontation with warm understanding is a fast route to building client trust. The therapist prefers "fight" (approach) reactions versus "flight" (avoidant) reactions and pursues issues the client attempts to avoid in order to mobilize the clients coping energies.

*Assumption 2: Clients can change if they choose.* Although this assumption is not based on the premise that everything is conditional to will power, clients are ultimately responsible for their own feelings and behaviors, for all of us largely create our own reality. Negative perceptions and resistance to change can be altered to reorganized perceptions and positive will. At the present time, we are not saying that a profoundly deaf person can become the music critic for the *New York Times*; but we are averring that clients are able to change behaviors, even though they often do not wish to do so or feel they can. In order to effect change, the provocative therapist humorously agrees with the client's own perceptions.

*Assumption 3: Clients have far more potential for achieving adaptive, productive, and socialized modes of living than they and most clinicians assume.* A clinician's statements of hopelessness about a client are more reflective of the clinician's sense of powerlessness than of the client's potential for change. Clients can choose and maintain more psychosocially responsible behavior. Clinicians, like most people, do not like to admit failure. It is far easier to forsee a negative prognosis for the client than to admit, share, adapt to, and learn from clinical errors.

*Assumption 4: The psychological fragility of patients is vastly overrated both by themselves and others.* Humor, laughter, sarcasm, and paradox (all in combination with other therapeutic techniques), if used skillfully, will not only *not* demean a client's dignity, but will actually help them achieve a sense of their own identity and worth based on a broader perspective of themselves as persons and rooted in positively changed behavior. The provocative therapist views clients as having many strong, positive traits that are the basis for a new person. In humbrously overfocusing on what is wrong, dysfunctional, or deviant with clients, the therapist provokes them into asserting what is right, functional, and congruent with societal norms in themselves.

*Assumption 5: The client's maladaptive, unproductive, antisocial attitudes and behaviors can be drastically altered, whatever the degree or severity of chronicity.* When perceived by others as having the ability to change, clients drastically and in many cases within a short time make these positive changes. Conversely, the mentally ill and virtually any handicapped group, when aided and abetted by clinicians who purport to be enlightened, can frequently find easy excuses and rationalizations for their self-defeating and pathological behaviors. Our belief systems, personal and collective, and the reinforcing interaction between these two, form our reality to a far greater degree than we often times imagine.

*Assumption 6: Adult or current experiences are as at least if not more significant than childhood or previous experiences in shaping client values, operational attitudes, and behaviors.* Adults have more experiences to generalize from and abilities to process information, while a child usually responds only to certain messages and perceives in a narrowly selective way. If a therapist can "tap into" an adult's abilities and experiences, then the clients have a greater potential for change.

*Assumption 7: Client's behavior with the therapist is a relatively accurate reflection of*

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*their habitual patterns of social and interpersonal relationship.* The provocative therapist helps create a "true to life" situation in therapy using a wide variety of techniques. Among these are role playing, evaluations by significant others enacted by the therapist, and behavior shaping feedback. Reciprocally, the clients produce habitual defensive routines until sufficient counter-conditioning results in new affective learning and coping behaviors which can then be generalized to other situations.

*Assumption 8: People make sense; the human animal is exquisitely logical and understandable.* If clients are perceived by us as not understandable, then we simply do not possess all the relevant data to understand them. Provocative techniques are introduced to produce quick and spontaneously significant personal information from the client and engender in the therapist clear understanding about and accurate empathy with the client.

*Assumption 9: The expression of "therapeutic hate and joyful sadism" toward clients can markedly benefit clients.* Paradoxically, the judicious expression of "therapeutic hate and joyful sadism" can paradoxically markedly benefit clients. The fundamental reason that the mentally ill and social deviants frequently perceive themselves as unloved and rejected is simply that they are frequently unloved and rejected because of their eminently unlovable and socially rejectable behaviors within a given social context or system. Phony, professionally constrained acceptance of clients negativity and hostile behaviors is supplanted by the provocative therapist's genuine rejection of these behaviors; this is more "true to life", sets appropriate limits, and overcomes the problem of the generalization of the therapeutic effect.

*Assumption 10: The more important messages between people are non-verbal.* It is not what is said but *how* what is said that is often crucial. Furthermore, incongruity between verbal and non-verbal communications used by the therapist creates ambiguity,

a higher degree of suggestibility and receptivity to the therapist's powerful non-verbal messages. These highly positive non-verbal messages are incessantly used by the provocative therapist to counterbalance negative verbal feedback directed at the client's problematic behaviors.

### Hypotheses

Through clinical practice with provocative therapy two basic hypotheses have emerged which remain to be either proved or disproved with each new client. The first concerns the client's self-concept: "If provoked by the therapist (humorously, perceptively, and within the client's own internal frame of reference), the client will tend to move in the opposite direction from the therapist's definition of the client as a person." The second hypothesis focuses on the client's overt behaviors: "If urged provocatively (humorously and perceptively) by the therapist to continue his or her self-defeating, deviant behavior, the client will tend to engage in self- and other-enhancing behaviors, which more closely approximate the societal norm" (Farrelly and Brandsma, 1974 p. 52).

### Treatment

The provocative therapist endeavors to provoke clients to engage in five different types of behaviors:

1. To affirm their self-worth, both verbally and behaviorally.
2. To assert themselves appropriately both in task performances and relationships.
3. To defend themselves realistically.
4. To engage in psycho-social reality testing and learn the necessary discriminations to respond adaptively. Global perceptions lead to global, stereotyped responses; differentiated perceptions lead to adaptive responses.
5. To engage in risk-taking behaviors in personal relationships, especially communicating affection and vulner-

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ability to significant others with immediacy as they are authentically experienced by the client. The most difficult words in relationships are often "I want you, I miss you, I care about you" — to commit oneself to others (Farrelly and Brandsma, 1974, p. 56).

Since there is an underlining structured *system* to provocative therapy, clients frequently tend to evince discernible stages of process. In the first stage, clients feel astonished, incredulous, uncertain, humorously provoked and intrigued. Almost all clients return for subsequent interviews (well over 90 percent return based on clinical records and billings).

In the second stage clients begin to reorganize their expectations of the therapist and begin to realize that they, not the therapist, must change.

During stage three, clients' affective and verbal content become increasingly integrated. Also clients typically become more rational and attempt to demonstrate specific, easily observable and measurable behaviors to disprove the therapist's description of them.

In the fourth stage clients present extra-therapy behavioral coping evidence to prove that they have changed. The clients are able to laugh at their old selves. They become more assertive, process oriented and appropriately tentative with less rigidity in their definition of self. Relationships outside therapy involve risk taking behaviors that are socially adaptive.

Not every interview in provocative therapy provokes all these client behaviors, but in every provocative therapy interview *some* of these behaviors are provoked.

In the following verbatim interview samples (during which the senior and junior authors were therapist and co-therapist), space and time do not permit extensive illustrations of provocative therapy. Despite the limitations of these samples, however, in our judgment they strongly state that these samples, however, in our judgment they

strongly state that these hearing impaired clients present problems similar to those of hearing clients: problems of identity and emotional-social problems of living with relationships and in work.

### First Case Example

The first client, Betty (a pseudonym), is a twenty-five year old, post-lingually deaf woman. She had excellent communication skills, was able to lipread, used expressive oral skills, and signed in pidgin English (a mixture of English and American Sign Language — ASL). She recently graduated from Gallaudet College, moved to the Midwest, and initially had problems of adjusting to a new city. She was intelligent, attractive, and at times acted coquettishly within the interview. The only deaf child in her family, she was never involved in therapy before this interview and was gainfully employed when the interview occurred. Throughout most of the interview Betty signed and simultaneously spoke orally, using English syntax and obviously demonstrating her awareness of idiomatic expressions within American hearing society.

Asked by the therapists what she wanted to discuss, the client immediately spoke of her fears of dealing with therapists who were unaware of the psychological and sociological aspects of deafness. But when further questioned, she defined her problems as being related to moving to a new city.

Client (Matter-of-factly): I think all the implications of deafness are not recognized in this town. Every person that comes from Gallaudet to here is going to experience the realization that the outside world is not Gallaudet and you don't get the kind of understanding that you do of the implications of deafness as you would at Gallaudet. I've met a couple of young, single deaf men since I've come to this town and I'm not very impressed with them.

Therapist (Nodding agreement): They're low lifes, low types—

C. (Agreeing): Right.

T. (Leaning forward placing his right hand

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on her knee): Most men *are* (low lifes), whether deaf or hearing. (Leans back, withdrawing his hand, grins, gestures palm upwards toward her, raises his eyebrows questioningly.) Huh?

C. (Laughing): *True!* (Client and therapists laugh together.)

But. Uhm, that's not saying that they are *bad*, or that's not saying that they are . . .

T. (Interrupting): Most men . . .

C. (Finishing): No good.

T. (Continuing): Most men *are* bad! (He pauses, leans forward, resting elbow on arm of client's chair, taps her knee twice with right forefinger, begins 'counting' with his right fingers) That's why God, Nature put women on this earth—

C. (Grinning, interjecting): To balance out the bad?

T. (Hooking her left little finger with his right index finger, gently flicking the tip of her finger several times with his thumb): No, to make men better, to reform men. (Laughing and grinning, releasing her hand, he gently taps her knee with the back of his hand, gestures palm upwards with a 'See?' expression on his face, leans back in chair, pauses, leans forward again, taps her knee with the back of his hand, again gestures palm upward.) Didn't you know that?

C. (Grinning continuously, laughs quietly): Oh, I always thought that when God created man, He was only making a rough draft.

T. (Grinning): Yes! But when He created women, (he makes two curves with his hands) that was the essence of perfection. (Laughing to co-therapist) How do you say that?

C. (Laughing, she voices): Of course! (signs simultaneously "That's normal.")

T. (Laughing, shrugging shoulders): We're agreed! No culture shock.

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Then, later in the interview:

T. (Leans forward, resting his arm on the arm on the arm of her chair):

Well, you're intelligent . . . uh, educated and, uh, let's face it, (turning to co-therapist) let's admit it, (turning back to client) you're cute. (Leans back, client laughs; therapist laughingly continues). Now where are you going to find a cute, intelligent, educated guy? Who's also deaf?

C. (Grinning, laughing): You tell *me!*

T. (Emphatically): Yeah!

With the problem now humorously re-defined as finding a cute, intelligent, deaf man, the therapist begins to give immediate feedback about the client's non-verbal behavior.

T. (Leaning forward, taps her knee twice with the palm of his hand, then points at her hands): You, you don't just communicate physically with your hands, you communicate also (touching her wrist) with your eyes (touches her knee) with your posture (therapist pulls back, folds hands on his chest, tilts his head, tucks his chin into his right shoulder,) with your looks (gently touches her knee with the back of his hand). . . . (tilts his head again) the tilt of your head (looks at co-therapist watching him sign, leans back) . . . and even the tone of your voice.

C. (Grinning): I wouldn't know about *him*.

T. (Flicking his right ear lobe with the tips of his fingers): Ahh, but *I* can hear it! (client and therapist laugh, therapist points at her face) See the way you do your eyes right there, you — (touches her knee, then points back at her) and right now look at your bodily posture (exaggeratedly role playing her non-verbal behavior, while she grins, laughs, and squirms in chair). Oh! Great big you . . . don't uh . . . take advantage of . . . poor little me. (Patting "poor little Poopsie" tenderly on her knee, his head tilted,) Yeahhh . . . *very* feminine. Tricks, ploys, and strategies (turning to co-therapist, grinning) How do you say that?

Co-therapist signs to her as she grins and laughs warmly; a pervasive, warm camaraderie is tangibly present and obvious between co-therapists and client.

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C. (Nodding, grinning, voicing): Strategies.

Co-T. (Laughing): I can't even spell it!

T. (Points at her.): Yeah, strategies . . . she's got it (Places right index finger on client's knee, turns to co-therapist) Womanly wiles, . . . say that . . . crafty (looking back at client) . . . you communicate on multiple — many levels — not just with your hands.

C. (Cautiously): Well . . . I agree with that.

T. (With "surprised innocence"): Well, *thank you!*

We have been depicting in a highly detailed manner the therapists-client interactions; from here on we are largely omitting the non-verbal qualification of the verbal messages (a massive, significant deletion we are well aware) and merely summarizing the verbal content only for the rest of the interview.

The therapist and client discuss social relationships with men and the difficulty of communicating on any real substantive level with either hearing or non-hearing men. The therapist states that finding "Mr. Right" is the age old problem of women, thus getting at her exceptional sets. The client denies "looking for Mr. Right" and indirectly gives her "laundry list" of expectations regarding relationships with males in a rather over-intellectualized way.

She talks about her desire for high-consciousness relationships with males on her own terms. The therapist replies that since she is cute, this is a further handicap beyond being deaf, and makes men think and act on a "low level" with her. The therapist's solution: lower herself to the "low level" of men — then she can have relationships with them. She laughs, grins, protests this, asserts herself and affirms her "pride in her good looks."

Since female attractiveness is a problem in male-female relationships, the therapists suggest the zany solution that Betty should "pray for ugliness" in order to have high level conversations with men. Again she laughingly protests, and confidently engaging in reality testing, states "*that's their problem!*"

They discuss her former marriage and the therapist asks who dumped whom, and is she finished with brute, beast men? This provokes differentiation learning, specific reasons for her divorce, and partialization of female generalizations regarding men (Betty laughing: "Not *all* men are brutes and beasts").

The theme of her new social life as a divorcee in a new town is discussed. The therapist suggests that she wait for "Mr. Right" to discover her and suggests further that she might "declare an armistice in the battle of the sexes." This provokes her to examine her alternatives in both work and relationships; she laughingly agrees with some of the therapist's points, and stoutly rejects others. Throughout this discussion she seems unhesitatingly sure of herself and shows this in her choice of words, the spontaneity of her responses, her body language, etc.

The theme is developed about her controlling behavior in relationships and about the difficulties of communicating across sex lines. The therapist communicates about her communicational patterns and says that women's favorite sport is reforming men. Why are "women always smarter than men?" Betty laughs, and examines her sexual biases towards men who are "bad, dumb, and in need of lots of reforming."

Throughout the remainder of the interview the client engages in humor, laughter, making jokes about herself, reality testing, self-affirmatory and assertive behaviors — all of which are typically provoked in provocative therapy clients. Thus the question, could provocative therapy be employed in working with hearing impaired clients has, we strongly suggest, been answered in the affirmative — based on this interview.

### Second Case Example

The transcript of this second case example uses English syntax for the remarks of both client and therapists. During the actual interview, however, the therapist's remarks were interpreted into ASL, and the client responded in ASL.

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Jack is a twenty-two year old, prelingually deaf man. He is unable to lipread or use expressive oral skills and communicates with ASL as his primary mode of communication. He has had a history of school behavior problems (such as fighting and truancy), drug and alcohol abuse, and has an unstable job history. He has never formally graduated from high school and has very limited writing skills. He is perceived by those who know him as often behaving very irresponsibly in his personal relationships and with money. Most of his friends are deaf and he is the only deaf individual in his family, which has basically abandoned him. He has had a foster family placement in the past. Currently, he lives independently with a roommate in an apartment. He presents himself in the interview as having no problems and being a reformed person from past problems. He is working but anticipates being laid off from work.

Therapist: How old are you?

Client: Twenty-two.

T. Can you lipread?

C. No, little bit, my mother and father, a little bit, words but sentences I can't understand.

T. Where is your family?

C. My mother lives in ....., and my father is dead.

T. Were you born deaf?

C. Yes, I was kicked out of my home. Before I had foster parents.

T. Are you on SSI or do you work?

The therapist is trying to rule out various problems or concerns by gathering general personal history parameters. The purpose is to "home in" on target problem behaviors.

C. No, working.

T. Where are you working?

C. Factory work, but I'm trying to find information about SSI. I might be laid off in December.

T. Do you live alone?

C. No, I have a roommate.

T. Another deaf person.

C. Yes.

T. Do you have any other person counseling you or helping you?

C. No, just VR (Vocational Rehabilitation counselor for job).

T. Do you drink much?

C. Yes, a lot.

T. (Turning to co-therapist) At least he would not be raucous and loud!

We have a good idea now that the client has had some behavioral problems in the past from referral information and from the client. Drinking, school behavioral problems and possible trouble maintaining a job are some identified "target problems". Humorous provocation begins with the therapist's observation, "At least he would not be raucous or loud!"

C. Before, yes, my actions were bad, but now I have changed.

T. What were your actions before?

Client gives a generalization ("yes, bad before but now changed"); the therapist asks what *specific* actions were bad. Concreteness and specificity is frequently requested in provocative therapy in this context.

C. I would stay out late, drink. Go out with some guys. Drink much beer.

T. (To co-therapist) He was a bad boy.

C. Foster parents were deaf. They know much about my trouble.

The client agrees comfortably with the therapist's use of the moral model of behavior (vice — virtue, good — bad) and feels emphatically understood by the therapist within his own frame of reference.

T. So, now you are reformed. So there's no problem. How's your love life?

The therapist perceives the client as young and good looking and possibly having problems in other areas of human relationships. After having "homed in" on *past* problems, the therapist wants to focus on *present* problems for one overriding consideration:



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What is "wrong" (dysfunctional) is wrong now.

C. I date hearing and deaf girls.

T. How did you get a girl friend if you were bad *and* deaf?

C. No, girls were nice, I brought them home. Deaf easy to talk to, hearing needed to write.

T. But how did you get a girl friend?

C. Start communicating with them.

T. You are a good looking guy (turning to co-therapist) but he's a *bad* shit.

C. (Laughs).

T. Many gals are attracted to good looking bad men. And I figure that's how you got gals.

C. No, not really true. No, girls don't like a bad person. They like to talk nice. Before when I was bad they didn't like my perspective of life.

T. Good women like to reform bad men. They like to change their behaviors.

The therapist is dealing with cultural stereotypes to provoke psycho-social reality testing in the client.

T. God put women on this earth to make boys and men good. Now that you are good (turning to co-therapist) I predict he will *never* have a girl friend!

C. I don't know about the future (Client stares, looks shocked.)

A typical response of a provocative therapy client is to react with astonishment or disbelief almost in a trance-like manner when provoked, thereby becoming more receptive to discrimination learning (i.e. interruption and differentiation of his global perception and global reaction patterns of thinking-feeling-behavior.). Discrimination in thinking about problems begins.

T. If he's going to get a girl friend he must get bad again. That's how a girl will become attracted to him. Being handsome is not enough.

C. Girls don't like bad behavior, drinking, spending money.

T. No, you are wrong. Women *love* to reform bad men. Handsome bad men they love even more.

C. Depends.

T. To change bad men makes women feel better about themselves.

C. (Shocked look on face; laughs).

T. So you are handsome. But if you become bad again you will have many girl friends.

C. (Disagreeing) Few, not many.

T. Do you want a weak, passive woman or a strong, bossy woman that tells you what to do all the time?

C. (Signs emphatically) I don't want bossy women.

A theme (bad men, good women) is now established which can serve as a metaphor for "reality" about human relationships, the client's place in this metaphorical reality, and his verbal and behavioral alignment to it. This metaphor can also serve as a mental arena in which his assumptive sets about his "reality" can be tested.

T. All women are bosses. Even weak women become bossy.

C. Not true.

T. My father said before women control my life.

C. (Nods).

Under the guise of discussing the male value system, the therapist provokes the client into showing his operational belief system.

T. Sometime in the future your girl friend will control you. Maybe start weak but later become very bossy.

C. (Sighs): Yes, deaf women are bossy, hard to control. Hearing women are nice. Deaf, behavior different; they pick on you, confront you.

This poor, unfortunate, handicapped client evinces remarkably creative utilization of his internal resources by transforming his handicap into interpersonal leverage with humane, compassionate, hearing women and easily

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influences them into being more nurturing, less confronting, less limit-setting and more sexually giving than deaf women.

T. Now, sometimes good men become good men to make them (women) happy and let the women boss them. Women are happy when they change men's behavior.

C. Women don't like men's bad behavior.

T. Right. Because the woman feels if the man changes too fast to make the woman happy . . . the woman thinks, the man is a boy. The man should try to keep being bad so the woman continues to be interested in trying to change the man. The woman then has a goal to live for: to change a man.

C. (Sighs, looks exasperated and nods) You're right. Many men get mad when women cheat on men. Men like to cheat on women. Most women like to have sex with one man.

T. Most men don't trust women.

C. Right!

T. And women think men want to have sex with many women.

C. (Signing emphatically) Right.

T. The way to make a woman happy is to *almost* let the woman feel that she is controlling the man.

C. Yes, women are hard to control but deaf (women) harder to control.

T. All women are the same. They want to control and change men.

C. Yeah (Appears to be in a trance state, looks down, glazed eyes, lost in thought.).

T. Now that you are not bad, you are no challenge for a woman.

Then ensues a discussion of "emotionally and mentally weak or strong" women; Jack says that he wants a "half and half — I don't want a bossy woman, but one who will explain, understand me . . . and I want a woman in my house to clean up." He further avers that deaf women are hard to control (both therapists laugh uproariously), "whereas hearing women are different — they're nice, and nice to talk to, while deaf women

are more difficult: they stand up to you, keep picking on you, confront you, and all that kind of of shit."<sup>1</sup>

The client and the therapist then laughingly engage in a discussion about women and the power structure and control issues in male-female relationships. The client agrees that, deaf or hearing, women want their way with deaf or hearing men — a woman wants to control her man. The therapist laughs loudly and states: "So deaf or hearing Jack has the same problem as Frank, Carl, or any other guy." The client nods vigorously, and signs "You're right." All three laugh as the therapist says, "I knew we could find some common ground."

The therapist further observes that women do not want bad men to change too quickly because then they will not respect the men. At this point in the interview, the therapist verifies with the client his understanding of what is being communicated to him. This "checking" is done throughout the interview to investigate the accuracy of the client's comprehension of signing as well as concepts being conveyed.

The therapist, elaborating and developing the theme of women's control over men, says that most women persist in "improving" a man even when he's acting ok. The client agrees with a sigh, looks exhausted, and slumps in his chair as though to say, "Oh my God, you hit it on the head." He signs, "You're right, you're right." Next there is a discussion of male and female sexual needs, and male-female expectations. The therapist apodictically states that to keep a woman happy a man must convince her that she is *gradually* improving and reforming him.

Jack begins to talk about Billy, his "bad-ass friend" who drinks a lot and gets in trouble constantly, etc. He seems somewhat jealous of Billy; in a non-sequitur, the therapist predicts that Billy will have many girl friends! The therapist explains why — because Billy is in such need of reforming that women find him *irresistible*.

The therapist further suggests that Jack also could become irresistible if he would only tell women that he used to be bad

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and in much trouble — stealing, committing acts of vandalism, drinking, using drugs, and being “bad with other women” — but that now he has changed. They will then be powerfully attracted to him, because women *love* a man who has demonstrated that he can change and is willing to do so! The therapist asserts forcefully that “boys and men are evil”, and that women are good and placed on earth to reform them — bad boys to be reformed by mothers and teachers, and bad men to be reformed by wives and girl friends. Since this is obviously so, the therapist says, he wonders what is the name of the good woman that changed *Jack's* behavior. After an initial attempt at projecting his responsibility for his anti-social conduct on other males, the client becomes assertive and self-affirmatory, protesting that he definitely changed his own behavior.

The therapist, laughing loudly, asks how can a bad boy influence himself to become good? Impossible! He states forcibly that the client is not giving credit to or being grateful to the good woman who used her influence to change him. As the client looks somewhat disconsolate and frustrated, the therapist suggests that perhaps it was Jack's foster mother.

The client immediately looks more alert and nods agreement that this was so; the therapist triumphantly and loudly exclaims; “Always a good woman changes a bad man into perfect man. Bad man cannot change himself into perfect man. All bad men need a good woman to change them into a perfect man . . . I have talked to many, many women and they all tell me that!” The client smiles, nods and recounts in detail how his foster mother changed his bad behavior: “She changed my life.” The therapist, with a triumphant sigh of relief, states that “I *knew* we could find the woman who reformed him!”

T. (Emphatically, laughing): *There!* Yes, *now* we know what woman changed you into a good man. A bad man can't change himself; you need a good woman to do that. I have talked with many women that have told me that.

C. (Laughs.) My real mother and father influenced me to become bad. But my foster mother told me, “Don't do that.” She explained for me. I understood. I wanted to change, they explained.

T. You changed because out of fear. Your foster mother threatened you, scared you, about the police. So reluctantly, slowly inside, you didn't want but you agreed. You didn't want jail.

C. Right, don't want jail, foster mother explained, can't be free.

T. Boy, are you a bad boy *forced* to be good!

C. Yes, they forced me. Told me, police would catch me, put me in jail.

T. You are the same as other men. Terrible, bad, fun-loving man who was changed by a woman.

C. Right. I don't want trouble, no fun, you can't drink — better to be free.

T. Right, ok, yes, women say to men, “You want trouble?” I will show trouble. With no fun.” Then men say, “I don't want *that* trouble I want *fun* trouble!”

Provocative therapists sharply distinguish between fear, shame, and guilt as conditioning modalities and consciousness levels in the socialization process of every person. (1) Fear is the felt experiencing of, “I have done something, and, if you find out, you will *do* something unpleasant (punishment) to me because of it.” (2) Shame is the felt experiencing of, “I need your approval, and if you find out what I have done, you will disapprove of me.” (3) Guilt is self-referred, and not that visible or frequent, at least in the initial stages of therapy. It is the felt experiencing of, “I have done something which I sincerely regret, because such actions are not consonant with the type of person I want to be and become.”

Provocative therapists believe that the majority of clients evince far more fear and shame than guilt. In lumping together these three powerfully motivating negative reinforcers and levels of consciousness under “guilt,” the clinical literature frequently confuses the issues for both therapist and client

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alike. Accurate empathy for clients, speaking their language or a language clients can understand and that resonates in their experiencing, and applying the appropriate reinforcers (positive as well as negative) for change, all seem contingent upon the therapist realizing what level of development in the socialization process clients have reached.

In this case, Jack is other directed and feels fear of punishment and shame as his major motivators for avoiding antisocial behaviors. The therapists, realizing this, frame their replies at these levels, fully cognizant of the ancient adage "Never try to teach a pig to whistle. You will merely tire yourself out and annoy the pig."

T. Most men become good because they are afraid.

C. Yes, right.

T. Maybe when you are laid off from work you can start fun trouble. Then you will have time for fun trouble.

A discussion ensues about the increasingly severe consequences of anti-social behavior after a young man turns eighteen — suddenly, there are no more "slaps on the wrist", but jail sentences, probation, etc. The client emphatically agrees and launches into an hilarious story of how he got mixed up with two "bad asses" in New Mexico who were driving a car while drunk, smoking pot, and firing guns at passing motorists when he, Jack, was in the back seat asleep. Arrested by police, they were all photographed, finger printed, and thrown into jail. Bailed out the next day, his two "friends" asked him to continue driving with them! He flatly refused and fled — hitchhiking 1,500 miles for a week through blinding snowstorms in the dead of winter back to his home state without even bothering to recover the money which he had lent the two rengades. In no uncertain terms he asserted that he has been avoiding these types of fellows ever since.

Throughout this interview the client asserted himself frequently, laughed humorously, smiled, and engaged continuously in psychosocial reality testing. He was provoked

to list highly specific, easily observable behaviors of his friends which had decidedly undesirable effects on him, and which were sources of significant learning for him.

He is undergoing a rather difficult transition period from exciting, self-defeating rebellious, jail-inducing behaviors with rather anti-social companions to more acceptable, socialized behavior with more "boring, straight people". He is beginning to separate himself off from these types of companions; he is, however, still in the process of transition — and his new "self", with its attendant satisfactions and rewards, has not yet fully emerged.

### Discussion

Some additional remarks about using provocative therapy with hearing-impaired clients, are appropriate here. In establishing the process of communication with these two hearing-impaired clients a brief assessment of their sign language preferences and abilities was conducted both before and throughout the interview. It was found that both the style and manner of signing could be modified to intensify or decrease provocation, and to increase or otherwise alter levels of comfort and support. In other words, the communicational content of signing can be qualified just as style and manner of oral speech (tone of voice, facial expression, rate of speech, bodily posture, etc.) can qualify nonverbally the content of the spoken word. Just as the dictum "It's not what he says, but the *way* he signs it" applies with equal validity to the signer. Frequently, therefore, the *manner* of signing can markedly reinforce the content of signing or so incongruently qualify the content as to become a separate communication or issue in and of itself.

### Summary and Conclusions

A brief synopsis of provocative therapy was offered. Two cases of hearing impaired clients were presented with illustrative samples of verbatim transcript from provocative therapy interviews with them. It is concluded that provocative therapy is a very appropriate form of therapy with hearing impaired clients and rapidly provokes as-

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sertive, self-affirmatory behavior and reality testing behaviors, all of which are indicative of psychotherapeutic change.

### Footnote

1A month subsequent to this interview it was learned that the client tried to move in with a woman and live off her earnings. The woman reported that Jack would have to get himself in line. The characteristics of this relationship strongly suggests the therapist was "on target" in the interview discussing male-female control issues with Jack.

### Bibliography

Farrelly, F., and Brandsma, J. M. *Provocative Therapy*. Cupertino, California Meta Publications, 1974.